# Report of Termination of Disability and/or Payment

## U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

**Part - A General**

| 1. Name of Injured Employee (last, first, middle) | 2. Social Security Number | 3. OWCP File Number (If known) |
|---|---|---|
| | | |

| 4. Department or Agency | 5. Bureau or Office |
|---|---|
| | |

6. Name and Address of Reporting Office (Include Zip Code)

| 7. Date and Hour of Injury (Mo., day, year) | 8. Date and Hour Stopped Work (Mo., day, year) | 9. Date and Hour Pay Stopped (Mo., day, year) | 10. Date and Hour Returned to Work (Mo., day, year) |
|---|---|---|---|
| ☐ AM ☐ PM | ☐ AM ☐ PM | ☐ AM ☐ PM | ☐ AM ☐ PM |

11. Employee's Work Week On Return To Duty If Other Than Monday Through Friday

**S M T W T F S**

12. Present Pay Rate If Different From That Received At Time Employee Stopped Work.

| a. Base Pay | b. Subsistence | c. Quarters | d. Other (Specify) |
|---|---|---|---|
| | | | |

13. Inclusive Dates Employee Received Pay For Any Part of The Period of Absence Because of:

| a. Annual Leave | b. Sick Leave | c. Other (Specify) |
|---|---|---|
| From: Through: | From: Through: | From: Through: |

14. Has Employee's Work Assignment Been Changed Because of Disability Resulting From This Injury?

☐ Yes ☐ No If Yes, Describe The Type of Work Employee Is Performing.

| 15. If Interrupted, Show Dates Deductions For Health Benefits and/or Optional Insurance Were Resumed (Mo., day, year) | 16. If Health Benefits Option Has Changed Since Disability Began, Show New Code Number and Date of Change (Mo., day, year) |
|---|---|
| Health Benefit Optional Insurance | Date |

17. Remarks

**Part - B Continuation of Pay**

| 18. Inclusive Dates That The Employee's Regular Pay Continued During The Period Of Disability. Do not include period of sick or annual leave (Mo., day, year) | 19. Show The Gross Dollar Amount Of Regular Pay Which The Employee Received During The Period Of Disability. Do not include pay received for sick leave or annual leave. |
|---|---|
| From: Through: | $ |

20. If Pay Rate Changed During The Period Employee Was Receiving Continuation Of Pay, Show The Date of Change (Mo., day, year)

21. If Pay Rate Changed During The Period Employee Was Receiving Continuation of Pay. Give New Rate

| a. Base Pay | b. Subsistence | c. Quarters | d. Other (Specify) |
|---|---|---|---|
| | | | |

| 22. Signature of Supervisor | 23. Title and Office Phone Number | 24. Date (Mo., day, year) |
|---|---|---|
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